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Research Article

# When patients cry in the appointment: the experience of Residency preceptors in Family and Community Medicine

## Quando o paciente chora na consulta: a experiência de preceptores de Residência em Medicina de Família e Comunidade

## *Cuando el paciente llora en la consulta: la experiencia de preceptores de Residencia en Medicina Familiar y Comunitaria*

Marcia Cristina Lemos dos Santos[1], Gabriela Sobrino Porto Bastos[2], Aline Stefano Mantovani[1], Bianca Porto Santos[1]

[1]Secretaria Municipal do Rio de Janeiro – Rio de Janeiro (RJ), Brazil.
[2]Prefeitura de Joinville, UBSF Ulysses Guimarães – Joinville (SC), Brazil.

## ABSTRACT

**Introduction:** During clinical consultations performed in Primary Care, it is not uncommon for patients to cry. However, the professionals that operate in this scope may feel unprepared to deal with this scenario, due to the lack of skills knowledge for the approach to patients with this kind of demand. **Objective:** This study aims to list and categorize techniques to approach a crying patient, through interviews with preceptors of the Family and Community Medicine (FCM) Residency Program from the Municipal Government of Rio de Janeiro. **Methods:** 16 preceptors were interviewed, and those interviews were recorded, transcribed and later analyzed according to Bardin's precepts. **Results:** As a result, we obtained a compilation of 94 quotations of non-verbal techniques and 27 of verbal techniques, as well as their learning methods, which occurred mainly through knowledge obtained during the Residency in FCM, practical experience and reading of related topics, highlighting the references about clinical communication. Moreover, reasons for patients crying, doctors' feelings, objectives of the techniques and whether they were considered to be helpful to both physicians and patients in this situation, were also categorized. **Conclusions:** It was concluded that the applied techniques belong to the set of clinical communication tools, based on empathy and bond, and that the first contact with these usually occurs at the FCM Residency and is later improved with clinical experience. In this context, stands out the importance of the emphasis given to the topic during specialization and continuing education for the benefit of the physician and the patient.

**Keywords:** Crying; Nonverbal communication; Physician-patient relations; Clinical competence; Education, medical.

**Corresponding author:**
Marcia Cristina Lemos dos Santos
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## RESUMO

**Introdução:** Nos atendimentos clínicos realizados na Atenção Primária, não é incomum que pacientes chorem durante a consulta. No entanto, os profissionais que atuam nesse âmbito podem não se sentir preparados para lidar com esse cenário, em virtude da falta de conhecimento de ferramentas para lidar com esse tipo de demanda. **Objetivo:** Este estudo propôs-se a elencar e categorizar técnicas para a abordagem ao paciente que chora, por meio de entrevistas realizadas com preceptores do Programa de Residência em Medicina de Família e Comunidade (MFC) da Secretaria Municipal de Saúde do Rio de Janeiro. **Método:** Foram realizadas entrevistas com 16 preceptores, que foram gravadas, transcritas e analisadas segundo os preceitos de Bardin. **Resultados:** Como resultado, obteve-se o compilado de 94 citações de técnicas não verbais e 27 de técnicas verbais, além dos modos de aprendizado delas, que ocorreram sobretudo por conhecimentos obtidos na Residência em MFC, na experiência prática e na leitura de temas correlatos, destacando-se referências sobre comunicação clínica. Ademais, foram categorizados os motivos para o choro dos pacientes, os sentimentos dos médicos, os objetivos das técnicas utilizadas e se se considera que elas auxiliam tanto médicos quanto pacientes nessa situação. **Conclusões:** Conclui-se que as técnicas empregadas pertencem ao conjunto de ferramentas de comunicação clínica baseadas em empatia e vínculo, e que o primeiro contato com elas ocorre geralmente na Residência em MFC; posteriormente elas são aprimoradas com a experiência clínica. Nesse contexto, destaca-se a importância da ênfase dada ao tema durante a especialização e da educação continuada em benefício do médico e do paciente.


**Palavras-chave:** Choro; Comunicação não verbal; Relações médico-paciente; Competência clínica; Educação médica.


## RESUMEN

**Introducción:** En las consultas clínicas realizadas en la Atención Primaria no es raro que los pacientes lloren. Sin embargo, los profesionales que actúan en este ámbito pueden no sentirse preparados para lidiar con este escenario, debido a la falta de conocimiento de herramientas para manejar este tipo de demanda. **Objetivo:** Este estudio se propuso a enumerar y categorizar técnicas para abordaje al paciente que llora, a través de entrevistas realizadas con preceptores del Programa de Residencia en Medicina de Familia y Comunidad (MFC) de la prefectura de Rio de Janeiro. **Métodos:** Se realizaron entrevistas con 16 preceptores, las mismas fueron grabadas, transcritas y analizadas según los preceptos de Bardin. **Resultados:** Como resultado, se obtuvo un compilado de 94 citas de técnicas no verbales y 27 técnicas verbales, además de los modos de aprendizaje de las mismas, que ocurrió sobre todo por conocimientos obtenidos en la Residencia en MFC, experiencia práctica y lectura de temas relacionados, destacándose referencias sobre comunicación clínica. Además, fueron categorizados motivos para el llanto de los pacientes, sentimientos de los médicos, objetivos de las técnicas utilizadas y se consideran que las mismas auxilian, tanto médicos y pacientes, en esta situación. **Conclusiones:** Se concluye que las técnicas empleadas pertenecen al conjunto de herramientas de comunicación clínica, basadas en empatía y vínculo, y que el primer contacto con las mismas ocurre generalmente en la residencia en MFC, siendo posteriormente mejoradas con la experiencia clínica. En este contexto, se destaca la importancia del énfasis dado al tema durante la especialización y la educación continuada en beneficio del médico y del paciente.


**Palabras-clave:** Llanto; Comunicación no verbal; Relaciones médico-paciente; Competencia clínica, Educación médica.

# INTRODUCTION

In clinical care performed in Primary Health Care (PHC), it is not uncommon for patients to cry during anamnesis.[1] This may be related to the fact that professionals who work in this area deal with patients in a comprehensive way, in different life contexts, addressing both physical and emotional issues.[2] Furthermore, there is evidence that people generally have a tendency to cry more often in hospitals and other health centers than in public spaces.[3]

However, these professionals may not feel prepared to deal with such a scenario, avoiding addressing issues that involve intense emotions in an attempt to prevent personal exhaustion and waste of time. This anguish can occur due to the lack of knowledge of tools to deal with this type of demand.[1] Techniques for approaching patients who cry in the consultation are not usually taught during graduation, so that newly graduated or little-experienced professionals, when found in this situation, may face feelings such as frustration and helplessness.[4]

There are still few studies that describe patients who cry at the consultation, most of them focused on the reactions of doctors and patients instead of describing techniques or tools used by professionals in these circumstances.[3] Even with the knowledge that each case is individualized, such techniques can

facilitate the conduction of the interview by health professionals, making consultations that could be difficult less uncomfortable and more productive for both professionals and patients.[5]

The objective of this study was to survey the techniques used by preceptors of residency in Family and Community Medicine (FCM) to deal with crying patients, according to their experience on the subject, promoting a meeting of methods for a more adequate approach to patients by PHC health professionals.

## METHODS

This is a qualitative, exploratory study, developed based on interviews applied to preceptors of the Family and Community Medicine Residency Program of the Municipal Health Department of Rio de Janeiro (*Programa de Residência de Medicina de Família e Comunidade da Secretaria Municipal de Saúde do Rio de Janeiro* – PRMFC-SMSRJ) during the work groups (WG), between the months of November 2018 and January 2019.

The sample consisted of 31 preceptor doctors of the PRMFC-SMSRJ and 16 who self-proposed to participate in the study. The WGs are groups with a limited number of preceptors, who meet periodically to prepare theoretical classes. For the interviews, a portion of professionals could be detached from the meetings in order to avoid compromising the activities developed.

Data collection was carried out through individual semi-structured interviews[6] conducted by the researchers, who are resident physicians and already knew the research participants because they had theoretical classes with the preceptors. The interviews were conducted at the place where the WG took place, moving one interviewee at a time.

The interview script was created by the researchers in order to access the memory of the participants regarding the consultations they had in which the patient cried in the consultation, their perceptions about themselves and about the other, the use of techniques and tools, as well as the origin of the knowledge about the techniques used. At the end, an open question was asked if the interviewee wanted to add more content to the interview.

The sample was selected by convenience, based on immediate availability, in the case of a non-probabilistic sample.[7] The interviews were recorded and later transcribed for analysis. Thematic analysis was performed following the precepts of Bardin.[8] The researchers, together, determined the categorizations and included the answers according to their perceptions, performing the grouping based on the semantics of the words.

For the development of this study, we considered as patients who cry in the consultation, adults who, at some point during the clinical interview, shed tears for any reason.

The present investigation followed all the steps foreseen by the Research Ethics Committee of the Municipal Health Department of Rio de Janeiro and the requirements of the Research Ethics Council (*Conselho de Ética em Pesquisa* – CONEP) of the Ministry of Health (Resolution of the National Health Council/*Conselho Nacional de Saúde* — CNS 466/12). All participants, through the Informed Consent, agreed and received due clarification regarding the objectives and methodology to be used in the study, as well as the information that the results obtained in this work could be published.

## RESULTS AND DISCUSSION

This study was motivated by the restlessness of the researchers when they find patients who cry during consultations. The opinion of the interviewees corroborates this feeling, since, of the 16 participants,

15 said that the topic in question was very relevant to the clinical practice of family doctors. In addition, they all reported seeing patients with this profile frequently.

The sample characteristics are described in Table 1.

**Table 1.** Characteristics of the sample of preceptors interviewed.

| | |
|---|---|
| **Gender** | |
| Female | 9 |
| Male | 7 |
| **Age** | |
| 25–35 | 13 |
| 36–45 | 3 |
| **Other specialization** | |
| Veterinary Medicine | 1 |
| Acupuncture and Chinese Medicine | 1 |
| **Time in preceptorship at PRMFC-SMSRJ** | |
| <1 year | 7 |
| 2–8 years | 9 |

PRMFC-SMSRJ: *Programa de Residência de Medicina de Família e Comunidade da Secretaria Municipal de Saúde do Rio de Janeiro*.
Source: Search results

The original objective of this study was to obtain a set of techniques to approach patients who cry in the consultation. However, during the conduction and interpretation of the interviews, new information was observed that proved to be relevant to the study, also becoming categories of analysis: reason for the patients' crying, doctors' feelings, techniques/tools used, forms/place of learning and objectives of the techniques, shown in Tables 2 to 4.

**Table 2.** Reasons cited by preceptors for patients crying

| | |
|---|---|
| **Physical** | |
| Pain | 1 |
| **Subjective** | |
| Mental suffering | 8 |
| Grief | 7 |
| Catharsis | 5 |
| Conflicting interpersonal relationship | 5 |
| Hidden complaint | 5 |
| Blackmail/manipulation | 3 |
| Guilt | 1 |
| Violence | 1 |
| Distress | 1 |
| Demand for attention | 1 |

Source: Search results

**Table 3.** Feelings experienced by preceptors toward patients who cry in the consultation

| | |
|---|---|
| **Positive** | |
| Sympathy | 2 |
| Pleasure | 1 |
| Honor | 1 |
| Negative | |
| Distancing | 3 |
| Anxiety | 2 |
| Awkwardness | 2 |
| Insecurity | 2 |
| Nervousness | 2 |
| Affliction | 1 |
| Distress | 1 |
| Discomfort | 1 |
| Suffering | 1 |

Source: Search results

**Table 4.** Techniques and tools used to manage patients who cry in consultation.

| | |
|---|---|
| **Verbal** | |
| Questions | 13 |
| Specific phrases | 11 |
| Verbal mirroring | 2 |
| Approach to ICE and PSO* | 1 |
| **Non-verbal** | |
| Silence | 14 |
| Offer a handkerchief | 11 |
| Touching | 11 |
| Change in posture | 8 |
| Hugging the patient | 6 |
| Physical approximation | 5 |
| Environmental protection | 5 |
| Listening | 4 |
| Giving space to talk | 4 |
| Looking in the eyes | 4 |
| Holding hand | 4 |
| Crying with the patient | 3 |
| Allowed delay | 3 |
| Nodding | 2 |
| Genogram and Ecomap | 2 |
| Change in facial expression | 2 |
| Offering water | 2 |
| Patient observation | 1 |
| Patient distancing | 1 |
| Body mirroring | 1 |
| Spatial organization of the office | 1 |

*ICE and PSO: ideas, concerns, and expectations; psychological, social, and occupational.
Source: Search results

It is important to emphasize that, during the interviews, the participants recover memories to narrate their experiences. The reasons that appear in the narratives may be the most significant or those that had the greatest impact on professionals, not necessarily reflecting the frequency of cases.

Effective communication is essential for providing quality medical care[3]. However, some professionals may be reluctant to address the patients' feelings as they find the situation too challenging. In addition, they lack therapeutic tools to deal with these emotions.[1]

Throughout the interviews, many of the causes cited for the patients' crying (Table 2) were, in fact, related to their feelings, according to the speech of interviewee 1: "*Sometimes, the patient arrives at the 1st, 2nd consultation and cries, [...] for a person to open up to you at this point, it's because they are in great mental suffering*." However, crying was also mentioned as a form of manipulation or blackmail, which can influence the doctors' attitude and the conduct of the consultation, as mentioned by interviewee 8: "*It is very common that if she [patient] demands something and someone denies it, she starts crying. It's a cry that I respond to differently, I already know that cry, it's almost a kid's tantrum*." In the literature, the main negative emotions associated with crying are sadness, anger, anxiety, and frustration; the positive causes are relief and happiness.[9]

Hidden complaints were also cited as causes of crying, as stated by interviewee 5: "*The subgroup [of patients] who have a complaint different from the apparent reason for the consultation, different even from the physical health problem and, during the consultation, there are several emotional manifestations that can go through crying*." According to Carrió, certain reasons for consultation appear between the lines of the official reason for the visit, which he calls the "business card", as there is a belief that some demands are better received by professionals than others.[5]

In fact, eventually, demands related to emotions, psychological issues, and crying itself can trigger feelings (Table 3) such as discomfort, anxiety and insecurity in doctors,[3,10] which was stated by some interviewees: "*Especially when the person has not yet told you what happened and they start crying, this causes a lot of anguish in the doctor, because you don't know why the person is crying, you don't know how you can help*" (E1). The act of crying together with the patient was cited by some with a negative connotation: "*When I started at 30 [years old] I didn't have all the reserve I have now. Someone would start crying and I would start crying too*" (E6). However, other preceptors considered that crying together was a way of showing sympathy, as in the following statement: "*Sometimes it was not possible to contain my own emotion, right? If you get emotional together with the person, I think it's a sign that you're really experiencing it with them*" (E15).

According to Gérvas et al.,[1] sympathy and empathy are necessary to understand the patient's feelings. Physicians are also expected to support patients in distress, in addition to dealing with their own feelings. Thus, taking care of the pain of others becomes one of the greatest responsibilities of the profession,[1] which is reflected in the speech of interviewee 2: "*Perhaps professionals are not emotionally prepared [...]. I think this is the biggest problem, because the chance of us recognizing each other and suffering together is very big*."

Sympathy and empathy are terms that are easily confused. The first occurs when doctors get emotional with the patient's report because they identify with the feeling. The latter is more versatile, as it does not depend on the physician's having feelings that are congruent with the patient's; it is the ability to understand another's situation, perspective, and feelings and to share that understanding with them.[11]

In some contexts, it is possible to recognize empathy as a tool that must be put into practice in order to promote greater diagnostic accuracy, therapeutic adherence and patient satisfaction, for having their

complaints covered, and for the doctor, for better organization and structuring of the consultation, time management, and prevention of additive demand, as demonstrated in the literature.[10] These objectives were also mentioned in the interviews:

"*After I started to understand and master the techniques, what improved was my care and the time of care, because initially these patients took up an hour of my schedule, [...] now I can manage it in half an hour if it is a very complex case, 15 to 20 minutes and still giving them space to cry freely and for me to understand exactly what is going on*" (E12).

Non-verbal communication covers about 93% of the possibilities of expression, qualifies human interaction, influences the perception and understanding of words, in addition to allowing one to understand the interlocutor's feelings. The good use of non-verbal communication aims to avoid iatrogenics.[12]

Corroborating the literature, 80% of the techniques mentioned by the interviewees in the present study fall into this category. The main one was silence: "*A moment of silence, when patients start to cry, is a technique that works well because they will see that I am there to listen*." (E12)

According to Borrell Carrió,[5] functional silences provide space for patients to concentrate or cause a tension that leads them to say or do something that they did not initially intend to. In a study published in 2011,[3] it was observed that being silent, letting the patient cry, was the first reaction of doctors in most cases, combined with actions such as sitting on the side, making physical contact or offering a tissue.[3] Such gestures were also listed by the interviewees, which also included other techniques such as looking into the eyes and changing the facial expression:

"*But it's not an indifference silence, you know? I think body language at these times is important for us to pay attention to. [...] I place my hand on the table and make an attitude of approach, you know, with my body, I get closer to the person, or I make a facial expression that indicates I want to know what is going on*." (E10)

Physical contact, or touch, is another useful technique that can be used in all clinical care to demonstrate empathy, security and closeness.[12] This tool was also mentioned: "*I made some physical contact, and it is important in our culture to perhaps make some physical contact, hug, this kind of affective demonstrations in a moment of mourning maybe make some sense*" (E5). Here it is important to emphasize the importance of cultural competence in the use of techniques. Communication difficulties occur more frequently when there is a large cultural gap, and it is up to the professional to try to minimize these differences in order to promote adequate communication and therapy.[11]

By "touching", one can understand not only touching the patient, but also hugging and holding the hand: "*When it's someone I already have some bond with [...] I sometimes squeeze their hand, or get close to them*" (E9). Thus, in addition to cultural competence, a factor that seems to condition the use of this technique is the bond, which facilitates the relationship between health professionals and assisted patients.[13]

The use of some of the mentioned techniques may depend on the organization of the space and the place where the consultation takes place. This is because the use of the space is also a form of non-verbal communication.[12] Some preceptors mentioned ways to minimize possible obstacles generated by the environment: "*First, create a safe environment at that time, for example, prevent the consultation from being interrupted*" (E1) ; "*I also try to remove physical barriers from the middle of the way, [...] if I am behind a desk, I usually go to the side, so that the person realizes that I am closer*" (E9) .

The importance of changing body posture was also mentioned as a way of showing attention and encouraging patients to speak:

"*But then when I realize that it's happening [crying], I leave the computer, get out of the way and turn directly to the patient, and then I uncross my arms [...], lean back on the chair, reach back, get into a comfortable position for me and I let them talk and I listen. [...] sometimes I put my hand on my chin, like: 'let it out, I'm listening, yes, I'm sharing this moment with you'*" (E2).

Another technique used with similar objectives is body mirroring, mentioned by interviewee 6: "*we call it 'mirroring', to mirror the patient. [...]. We can also show interest through miming or not*".

Mirroring is understood as a technique which can be bodily or verbal. The former consists of responding with body movements comparable to those made by patients, without imitating them. Verbal mirroring, also mentioned throughout the interviews, occurs when the doctor resembles the patients' tone of voice and repeats their last words with a light question intonation, encouraging the patient to speak more.[14]

The grouping of facilitation techniques, such as the use of words or phrases by repetition, empathic expressions and questions, was characterized by Borrell Carrió[5] as the "*pulling the thread*" technique. For him, some patients have difficulty listening to themselves or elaborating their own feelings, so they benefit from this tool so that unstable feelings gain presence in the act of verbalizing them.

Encouraging patients to name the feeling associated with crying can help, as in the speech of interviewee 10: "*Trying to name it is something that we also need to ask, because sometimes the difficulty of stating the reason for crying is great and asking to name it is a technique [...] that helps, it even helps us to have an insight*." This ability to identify and name emotions is related to social competence and interpersonal experience and, in addition to being an indicator of psychosocial adjustment, it is considered a prerequisite for other skills, such as empathy.[15]

Of those interviewed, 14 said they had more difficulty in this situation at the beginning of their careers, however, all of them considered that the techniques helped in the management of these patients.

Although several techniques used by preceptors have been mentioned, specific chapters on the subject are not found in PHC books, according to Gérvas et al.[1] Still, about 70% of the speeches related to the way of learning these tools referred to formal methods, such as readings on related topics or learning during graduation, residency or preceptorship. The ways of learning these techniques are compiled in Table 5. It is worth noting that there were six statements specifically about learning through direct and reverse observation during the residency in FCM:

**Table 5.** Way of learning the techniques used in the management of patients who cry in the consultation.

| **Formal** | |
|---|---|
| Medical residency | 18 |
| Reading on related topics | 16 |
| Teaching at graduation | 5 |
| Medical preceptorship | 3 |
| External courses | 2 |
| Informal | |
| Personal experience | 13 |
| Instinctively | 5 |

Source: Search results

"*With my preceptors, watching consultations, under direct and reverse observation when I was a resident, observing... even without knowing the name or what technique it was, you could see they*

*would lead it in a way that... ended up working out and you reproduce it kind of without knowing why, but it works*." (E14).

Another way of learning would be informally, instinctively, as in: "*Before knowing this technique, I was already doing it without knowing I was doing it*" (E14); "*Confidence obviously also comes from the fact of having used certain approaches a few times and discovering that it starts to work a little better as it is used*" (E5). It is important to emphasize that feeling more confident in dealing with difficult situations is different from being comfortable with them, as highlighted in the speech: "*Connecting to the suffering of others is not easy, it's not supposed to be easy, so if it's ever easy, revisit it, because maybe you created some barriers there in that meeting*" (E11).

The way of learning, both by direct and reverse observation as well as instinctively, can be related to the concept of "hidden curriculum", which involves spreading knowledge through attitudes and values, by setting examples from teachers to students through practice and coexistence. It is what, even if not programmed or planned, is necessary.[16]

Finally, one of the interviewees highlighted the importance of mastering the use of these techniques according to the context rather than just applying them in a plastered way:

"*It's like playing an instrument, I mean, you can play an instrument without ever having studied it, but studying allows you to keep playing when the situation changes [...], you study more to be able to improvise better, actually, not to get stuck on techniques, you know?*" (E16)

Chart 1 presents the references cited by the interviewees.

**Chart 1.** Literature suggested by the interviewees to assist in the management of patients who cry at the consultation.

| **Books and protocols** |
|---|
| 1. "Patient-Centered Medicine: Transforming the Clinical Method", by Moira Stewart |
| 2. "Entrevista Clínica", by Francisco B. Carrió |
| 3. "10 Minutes for the Family", by Asen, Tomson, Young, and Tomson |
| 4. "The New Consultation", by David Pendelton |
| 5. "A Consulta em 7 Passos", by Vítor Ramos |
| 6. "Tratado de Medicina de Família e Comunidade", by Gustavo Gusso |
| 7. "The Six-Step `rptocol for Delivering Bad News", by Walter F. Baile, MD and Robert Buckman, MD, PhD |
| **Other authors** |
| 1. Emerson E. Mehry |
| 2. Gilles Deleuze |
| 3. Juan J. Gérvas |
| 4. Milton Erickson |

Source: Search results

## CONCLUSIONS

In view of the results found, it is clear that there is no list of specific techniques or skills to be used when patients cry in the consultation, despite this being a situation that occurred with all interviewees. The professionals mentioned the use of clinical communication tools applied to consultations in general, without the specificity of crying during the consultation.

According to the memories of interviewees, the reasons for patients to cry were mostly subjective issues such as mental suffering and hidden complaints. The feelings reported by the professionals were

both positive, such as sympathy and honor, and negative, such as anxiety and discomfort. The professional crying with the patient was not brought up as something bad or wrong.

The main techniques used by preceptors were categorized as non-verbal, mainly keeping silent, offering a handkerchief, touching or hugging the patient and changing posture, including removing barriers between the professional and the patient. Among the verbal techniques, most are specific questions and phrases that aim to encourage the patient to speak. In general, they aim to improve the doctor-patient bond by promoting greater user embracement, in addition to better structuring the consultation and time management by the professional.

The learning of these techniques occurred, above all, during the residency in FCM, through specific readings on topics of clinical communication and the improvement of this competence during professional practice. Thus, the importance of FCM residency programs, as well as Medicine courses, emphasizes the importance of teaching and developing communication skills on an ongoing basis. We hope that this article will serve as an incentive for theoretical-practical meetings to train skills to be used when a patient cries during a clinical consultation.

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## CONFLICT OF INTERESTS

Nothing to declare.

## AUTHORS' CONTRIBUTIONS

MCLS: Project administration, Formal analysis, Conceptualization, Writing – review & editing, Methodology, Supervision. GSPB: Formal analysis, Conceptualization, Writing – original draft, Investigation, Methodology. ASM: Formal analysis, Conceptualization, Writing – original draft, Investigation, Methodology. BPS: Formal analysis, Conceptualization, Writing – original draft, Investigation, Methodology.

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